‘We’re not monsters ... we’re just really sad sometimes:’ hidden self-injury, stigma and help-seeking

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“We’re not monsters . . . we’re just really sad sometimes:” Hidden Self-injury, Stigma and Help-seeking

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Abstract

The aim of this article is to provide an insider perspective on experiences of stigmatisation for people who engage in hidden self-injury. The vast majority of self-injury is recognised to be hidden, whereby most people who self-injure do not present to formal health services. By drawing on the data from 20 face-to-face interviews, conducted in community settings, with counselling clients with a history of self-injury and counsellors experienced in working with self-injury, I sought to provide insights into hidden self-injury, stigma and help-seeking. Through a Grounded Theory analysis, three categories were identified: (1) stigma and rejection; (2) fear and the need to rescue; and, (3) secret shame and self-stigma. Each category inter-relates to form the core category, "stigma permeates the lives of people who self-injure." My research demonstrates that social stigma surrounding self-injury interacts with self-stigma and compounds existent feelings of shame, thus restricting help-seeking and recovery. There is a need for service-providers and policy-makers to become aware of the multifarious manifestations of stigma, which reinforce the devastating impact of self-injury on people's lives.

Key words: Self-injury, Stigma, Help-seeking, and, Qualitative

"We're not monsters . . . we're just really sad sometimes:" Hidden Self-injury, Stigma and Help-seeking

Introduction

Self-harm is an umbrella term encompassing a range of behaviours including intentional drug overdose, with or without suicidal intent, and self-injury. Self-injury relates more specifically to self-inflicted damage to skin tissue through cutting or burning, acts which are generally conducted without suicidal intent (Klonsky, May & Glen, 2013). Contemporary research recognises the distinction between self-harm and self-injury although there remains definitional blurring, which has led to a degree of conceptual misunderstanding in clinical and academic discourse (Chandler, Myers & Platt, 2011). While self-injury is generally recognised to be non-suicidal in intent, recent research from the United States (US) has demonstrated that self-injury is an "especially important" risk factor for suicidal behaviour (Klonsky, Victor & Saffer, 2014, p. 566). Lifetime prevalence of self-injury has been estimated at 18% for adolescents and young people (Muehlenkamp, Claes, Havertape & Plener, 2012) and 6% for adults in the general population (Klonsky, 2011). Thus self-injury is a significant public health issue posing real concerns for society and policy-makers.

Research suggests that self-injury is a particularly stigmatised behaviour (Longden & Proctor, 2012). A stereotype commonly endorsed is that people who self-injure are 'attention-seeking' in the derogatory sense (Klonsky et al., 2014). However, the vast majority of self-injury is hidden (Gratz, Conrad & Roemer, 2002) because most people feel too ashamed to seek help (Longden & Proctor, 2012), which goes some way to dispel the myth that self-injury is used for secondary gain (Long, Manktelow & Tracey, 2013). Prejudice prevails in health services, whereby people who self-injure are perceived to be particularly difficult (Schoppmann et al., 2007) and their behaviour considered a waste of time and resources

(Simpson, 2006). Existing research has documented discriminatory practice such as delayed treatment (Long, Manktelow & Tracey, 2015; Longden & Proctor; 2012) and suturing cuts without anaesthetic (Pembroke, 1996).

Stigma has been defined as, "a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and 'less than'" (Pescosolido, Martin, Lang & Olafsdottir, 2008, p. 431). The concept of stigma has existed perennially however in the discipline of sociology, Goffman's (1963) work on stigma is lauded as seminal and enduring (Scambler, 2009). Goffman (1963) proposed a symbolic interactionist conception of stigma, as a social process created in social interactions. Goffman (1963) identified three types of stigma: abominations of the body, blemishes of individual character, and tribal stigma. People who self-injure experience a double stigmatisation, on the basis of abominations of the body; the physical traces of marks and scars and blemishes of individual character; the label of mental illness (Goffman, 1963). The level of stigmatisation is so profound because people who self-injure defy the most fundamental aspect of social order by inflicting injury on the body in a society increasingly fixated on body image. Subsequently, the impact of stigma on people who self-injure, has the potential to be powerfully detrimental to their capacity for help seeking, recovery and social integration.

Research on health-related stigma has proliferated since Goffman's (1963) seminal text, with considerable focus on issues such as HIV/AIDS, epilepsy, and mental illness in general (Scambler, 2009). Parker & Aggleton (2003) provide a useful framework, which demonstrates that stigma operates at structural, social and internal levels, to inhibit the life chances of people with HIV. The exercise of power is recognised to be central in

contemporary sociological conceptualisations of stigma, at both structural and individual levels (Link & Phelan, 2001; Parker & Aggleton, 2003). Structural stigma propagates and upholds environments of labelling, stereotype, prejudice, and discrimination, which are enacted and reinforced by social stigma between people. Internalised or self-stigma is the process through which the stigmatised group accepts the negative attitudes and subsequently holds feelings of self-blame and shame. Consistent with insights from modified labelling theory (Link, 1989), the consequences of self-stigma include shame, fear and hiding (Markowitz, 1998).

The Framework Integrating Normative Influences on Stigma (FINIS) is an innovative meta-theoretical model, which combines theoretical insights from micro, meso and macro level research to provide a foundation for understanding the effects of stigma on people with mental illness (Pescosolido, Martin, Lang & Olafsdottir, 2008). FINIS is based on Goffman's (1963) original symbolic interactionist conception that stigma is shaped in social interactions. However, FINIS expands on Goffman's (1963) thesis by recognising that people experience both affective and motivational impacts upon entry into social interactions, and that social relationships are shaped by social structures. Thus FINIS draws upon a range of theoretical approaches from social psychology and sociology to provide understanding about the factors shaping the stigma of mental illness at individual, treatment system and community levels.

The existing body of healthcare research on attitudes towards self-harm and self-injury has focused mainly on the perspectives of healthcare professionals in both medical and mental health settings (Anderson & Standen, 2007; Dickinson, Wright & Harrison, 2009; Mackay & Barrowclough, 2005; Shepperd & McAllister, 2003). The majority of research on attitudes

has been quantitative, using questionnaires to determine professional perceptions of self-injury and service users who engage in the behaviour. Research focusing on service user perspectives on attitudes towards self-injury is limited. Harris's (2000) qualitative study, which involved letter writing by service users, provided important insights into service user experiences in emergency departments, reporting evidence of negative and discriminatory practice by staff. Overall the evidence suggests that self-injury often evokes discomfort, anger, confusion and even disgust among care-providers (Babiker and Arnold, 1997; Shepperd and McAllister, 2003). Furthermore, stigmatised attributes and negative attitudes are strengthened by professionals' causal attributions, viewing the person to be responsible for their self-harm (Mackay & Barrowclough, 2005; Urquart Law, Rostill-Brookes and Goodman, 2009).

The role of healthcare clinicians is crucial in managing the treatment of people who self-injure and self-harm. However it would seem important to understand the role of mental health practitioners who work in this field because they tend to work on a long term basis, potentially possessing unique, in-depth insights into the experiences of people who self-injure. Previous research considered counsellors' experiences of working with self-harm and self-injury, and similar to healthcare professionals, it is clear that work in this field poses significant challenges for counsellors (Fleet & Mintz, 2012; Fox, 2011; Long & Jenkins, 2010). Counsellors can struggle to manage the competing demands of organisational policies on risk and the client's agenda for change, which might not include the cessation of self-injury. Fox (2011) suggested it is important for counsellors to be aware of the deleterious effects of communicating prejudice, consciously or otherwise, in reinforcing existent stigma surrounding self-harm and self-injury. As counsellors are an important point of contact for

people who self-injure when they access psychological care, it seems crucial to understand the practitioners' perspectives on their experiences.

Evidently, self-injury is a stigmatised and hidden behaviour. Moreover, the interaction of social stigma and self-stigma reduces the likelihood of help seeking, compounds existent feelings of shame and thus increases dependency on self-injury (Long et al., 2015). It seems imperative to understand how stigma and its consequences impact upon the person who self-injures, their relationship with themselves and with others. While Goffman (1963) relegated the role of emotion in social life, I sought to understand the emotions that foster stigma towards self-injury among practitioners and the emotions that stigma evokes in the recipient. This article seeks to provide understanding of the convergence between stigma and emotion in relation to self-injury. The FINIS (Pescosolido et al., 2008) offers a useful theoretical framework to enhance understanding about the factors shaping the stigma of self-injury at micro, meso and macro levels.

This article provides understanding about the experiences of stigma in self-injury from the perspectives of: (1) counselling clients with a history of self-injury and, (2) counsellors experienced in working with people who self-injure. By comparing and contrasting client and counsellor perspectives I sought to provide a more nuanced exploration of stigma in self-injury than has hitherto been conducted. Situating the study at a community level and recruiting participants from third sector services, facilitated a richer data set than formal clinical settings that have predominated research in this field. Additionally, the article advances existing research by illuminating the emotional and social impact of stigma upon the person who self-injures in wider society, the treatment system and at an individual level.

Methods

Data Collection

Individual face-to-face interviews were carried out by the author and audio-recorded with the participants' consent. A total of 20 interviews were conducted, with 10 clients and 10 counsellors. An initial interview guide was designed based on concepts identified from the literature review. The guide included questions about experiences of self-injury, disclosure, seeking help and counselling. Participants were invited to expand on their responses; follow-up and probing questions were used to elaborate on concepts that emerged during the interview. In keeping with GT (Corbin & Strauss, 2008), the interview guide was adjusted after each interview to include additional questions based on concepts that emerged during the interview process, that were posed to subsequent participants.

Recruitment

Participants were recruited (n = 20) by advertising in non-statutory counselling agencies and third level education in Northern Ireland. Participants self-selected to the research by contacting the author by email, once they had read the publicity leaflet. The researcher replied to their email and enclosed a copy of the participant information sheet (PIS). An interview was arranged at a time and date convenient to both parties, only when the participant had read the PIS, confirmed they met the inclusion criteria, asked any questions or clarified any issues and subsequently expressed a willingness to participate and signed the consent form.

Sample

Purposive sampling was used to recruit participants who would most appropriately inform the research question (Bryman, 2012), adopting a dual focus on the perspectives of clients with a history of self-injury and counsellors who work with self-injury. Counsellor participants

were accredited with a professional body and experienced in working with self-injury. The counsellor sample comprised seven women and three men, aged between 32 and 62 years, with a mean age of 46 years. They had between seven and 20 years of counselling practice.

Participants with a history of self-injury were: over the age of 18 years; reporting a history of self-injury; no longer engaging in self-injury; and accessing counselling at the time of research participation. The last criterion was designed to ensure the emotional safety of participants, so that they were in a position to avail of support if necessary. Four participants had a history of engaging in other methods of self-harm, in addition to self-injury. Five participants had a history of involvement with formal psychiatric services. The sample comprised two men and eight women, between the ages of 19 and 42 years with a mean age of 31 years.

Data Analysis

Data were analysed using the central tenets of GT (Corbin & Strauss, 2008), which involved the open, axial and selective coding of categories to identify concepts, subcategories and categories. This process was facilitated through the use of QSR International's NVivo 9 qualitative data analysis software (Richards, 2015). Data collection and analysis was an iterative process, which meant that each interview was transcribed and analysed as soon as possible after recording was completed and prior to the subsequent interview. The preliminary analysis began during transcription, which was carried out by the author immediately after the interview.

To ensure credibility (Corbin & Strauss, 2008), member-checking was employed (Creswell & Miller, 2001; Lincoln & Guba, 1985). This strategy involved sending the transcript along

with a summary of the transcript, which identified key themes, to the relevant participant for their perusal and verification, following the transcription and open coding of each interview.

Ethical Considerations

Ethical approval was granted from the university's Research Ethics Committee. Ethical procedures were rigorous to ensure proper ethical conduct throughout the research process on this complex and sensitive issue. To protect the anonymity of participants, pseudonyms were used throughout the research study. Prior to the interview, careful consideration was taken to assure participants that their consent was on-going. Participants were given a consent form to initial prior to recording to indicate their consent to participate. In addition, participants were advised of the possibility of future publication of the findings.

Findings

Three major categories were identified: (1) stigma and rejection; which presents participants' experiences of stigma surrounding self-injury in the community and society (2) fear and the need to rescue; which depicts participants' understanding of the manifestations of stigma within counselling services, and (3) secret shame and self-stigma; which captures perspectives on the internalisation of social stigma among people who self-injure. For the purposes of the findings the participants are identified using pseudonyms along with the following codes to distinguish whether they are client (CL) or counsellor (CO).

Stigma and Rejection

All the participants reported experiences of prejudicial attitudes towards people who self-injure. Stigma appears to be of profound significance in relation to self-injury, in that people

who self-injure may be stigmatised on account of both the physical marks on their body as well as an inferred denigration of their psychological well-being. The counsellors identified examples of how people who self-injure encounter levels of character defamation and negative, dehumanising labels as a result of lack of understanding:

> *Rachel (CO): I think there's not a lot of understanding about it, I think that they're all tarred with the same brush, you know that whole "pull yourself together, behave, there must be somethin' wrong with you, why would you do that? You must be nuts."*

The clients spoke about their own experiences of prejudice and discrimination in wider society because of their self-injury:

> *Anne (CL): like I have certainly noticed, especially when I was younger and I did cut and I had like active cuts, you know recent cuts, em, people were very judgmental.*

Clients reflected on negative experiences of judgment within their community, on the basis of self-injury as well as of perceived mental health problems more generally. For one participant, John (CL), experiences of prejudice within the community impaired his capacity to recover from the label of mental illness that was applied after a period of psychiatric hospitalisation during his teenage years:

> *John (CL): I was in that psychiatric hospital whenever I was 14 and I felt people treated me different afterwards, that didn't give me a chance to actually heal.*

Clients' awareness of stigma and prejudice towards them within the wider community evoked fear, which impacted upon their decisions to seek help. Many reported that they delayed seeking help and disclosing self-injury because of the potential repercussions for them, such as labelling, judgment and misunderstanding:

Megan (CL): I was absolutely petrified of, judgment as well, because [self-injury] is such a taboo subject, like even today and unfortunately it probably will be for a long time, self-injury and mental health.

Counsellors suggested that fear is the primary emotion underpinning the stigmatisation of people who self-injure, which encourages more hostile reactions such as anger and frustration among counsellors struggling to understand self-injury:

Jennifer (CO): People are frightened by self-injury, such as suicide, the word suicide frightens people, and so does the word self-injury.

Clients recognised the role of the media in perpetuating negative images of self-injury and mental illness more generally:

John (CL): the myth of psychiatric illness . . . maybe you hear about a court case where somebody tried to kill themselves two days before they killed their baby and then there'd be, "all people with psychiatric illness are killers, are baby killers."

Participants from both groups spoke of self-injury among young people being perceived as representing particular musical sub-cultures such as 'Emos' and 'Goths'. One of the clients, Martina, related that prior to her self-injury, she judged people who self-injured in terms of the cultural stereotype reinforced by the media. She subsequently recognised that this stereotype trivialises self-injury and is thus profoundly damaging to young people who are cutting in an effort to cope with severe emotional distress:

Martina (CL): if someone is self-injuring then it should be taken a lot more seriously than "oh right, you're an Emo" or "you're doing this all for attention, just wise up." Because it's not like that, it's just not like that . . . it needs to be taken seriously.

While this trivialisation is recognised to be potentially damaging by clients, the counsellors, who are broadly sympathetic and understanding of self-injury highlighted the role of musical subcultures as contributing to self-injury among young people:

> *Kevin (CO): counter-culture, we all have some kind of need to belong, young women, self-harm and eating disorders, on some levels it's become quite vogue, you have stars with eating disorders and self-harming, in celebrity world, Lady Gaga with histories of self-harming and Pink, ya know, there's counter-cultures there that are influencing these things.*

Even among those counsellors who viewed self-injury with compassion, there are those who conveyed latent judgments, which would necessarily impact upon their interactions with people who self-injure. Client Anne depicted feeling sensitised to potential judgment from professionals, which inhibited her capacity for recovery. Anne's narrative conveyed the sense that judgment was another obstacle to overcome in seeking self-change:

> *Anne (CL): But even when I did want to change I did feel, I felt really uncomfortable talking about it to professionals, I felt, I don't know if they were but I felt like I was being judged, and I eventually just had to get over that.*

This category provides insight into the participants' perceptions and experiences of attitudes towards people who self-injure in wider society. The findings demonstrated that awareness of stigma and experiences of prejudice impact upon the person's sense of self, their relationship with self-injury and their willingness to seek help.

Fear and the Need to Rescue in Counselling Services

The counsellors recognised that fear of self-injury replete within wider society, is also existent among counselling practitioners. This fear and ignorance manifests among

counsellors who feel a 'need to rescue' people and so provide short-term placatory interventions, which focus on stopping the behaviour and do not attempt to heal the deeper emotional wounds. One counsellor referred to this process as a counsellor's attempt to be a "sticking plaster":

> *Kevin (CO): also to be aware of what stuff this is firing up in us, our own fears, our own need to sort the person out, to want to be a sticking plaster, we've gotta avoid being a sticking plaster for the person.*

The need to rescue might become more powerful when working with clients who self-injure and counsellors could feel challenged in resisting such needs, which could result ultimately in the provision of unhelpful interventions:

> *Jennifer (CO): Little understanding and not even little understanding but not wanting to really understand, again just thinking that this is a behaviour that can be changed immediately, not understanding the issues behind it.*

This approach was described by the client participants as, "*not really dealing with the issues but symptoms*" (Anne) or "*treating people from a textbook*" (Ruth), whereby assumptions about motivations for self-injury were experienced as "*damaging*" (Ruth). Additionally, clients suggested that negative attitudes and stigmatising responses could lead to further self-injury:

> *Bret (CL): that freak-out reaction, if they're already self-harming they're probably already feeling at an all time low and already feeling pretty crap and then they get that freak-out reaction . . . it will just fester for some people it just becomes a lifelong thing . . . if they don't get any help there, what happens then? They're gone, they fade away.*

The findings reported on the tendency to negatively label people who self-injure, which imposes a dichotomy between "us" and "them" so that counsellors and other practitioners might consider clients as sick people who need to be either fixed, cured or rescued. One counsellor, Paul referred to this process in terms of the defence mechanisms; splitting and projection, whereby people project attributes onto others that they cannot accept in themselves:

> *Paul (CO): So I look at self-harm, there are two definitions of self-harm, there's that broader definition of self-harm that I think welcomes us all in and I challenge people to tell me that they don't self-harm because they do. And then there's the loaded term self-harm, which is the clinical term . . . So there's a kind of clinical thing that we use about people who hurt themselves but I think that's a defence mechanism because they [professionals] don't really understand it, they don't really like it because it challenges them on some either conscious or unconscious level, so we label "them" as "self-harmers" and we go "oh we don't do that".*

This idea suggests that many people are unable to cope with the powerful emotions evoked when they encounter self-injury and thus seek to separate themselves from the other by pathologising the behaviour, defining it as a clinical term. In this way the splitting and projection defend practitioners against the emotions that self-injury elicits in them, such as their own capacity for self-destructive behaviours or their own struggles to cope with emotional pain.

Five of the counsellors reflected on how their own attitudes and experiences have impacted on their feelings about working with clients who self-injure. They expressed how their attitudes have changed over time, where worry and fear may have predominated in the past,

with experience this has diminished, facilitating a deeper understanding of their clients who self-injure:

> *Mary (CO): So sometimes I would be concerned because it used to be the thinking that suicide and self-harm are linked and I would be tremendously afraid that they would take their own life. Now I feel more of a risk-taker and see that they're self-harming because they want to live and I've asked clients that.*

This category has demonstrated that labelling and a need to fix clients is an emotional defence, which diminishes the counsellors' capacity to understand the underlying pain that often motivates the self-injury. Fear of self-injury provokes an emotional self-protection defence among counsellors, resulting in the subsequent stigmatisation and labelling of people who self-injure, which further iterates the cycle of self-injury.

Secret Shame and Self-stigma

This category relates to the participants' perceptions about self-labelling; the attitudes that people who self-injure often hold about themselves. A profound sense of shame is reported to be a contributory factor in hidden self-injury. Moreover the diminished sense of self-esteem that leads to self-injury is further depleted through the internalisation of social stigma:

> *Phil (CO): Attitudes of people who self-injure to themselves, usually at the beginning of the work, no it's not very good, they think it's something they shouldn't be doing, although they also know it's something that they may need to do, they don't like the fact that they do it, so there's a range within that and that sense of how they judge themselves often falls into another pattern of undermining their self-esteem and undermining their self-worth.*

The findings showed that the emotions evoked among staff in the treatment system and people in wider society might be internalised by the person who self-injures, resulting in an obscured welter of conflict within the person and a perpetuation of the vicious cycle of emotional pain, hiding and shame.

> *Rosie (CL): I've recognised too that there has been, there has been a terrible stereotyping over the last, well in perpetuity, really, of people who self-harm, and it's something that you know, we're not ugly, we're not monsters, we're not psychotic, we're just really sad sometimes, and sometimes we just really hate ourselves for it.*

Clients reflected on their concerns that disclosing self-injury would negatively impact upon their future career choices, which caused them to delay their decision to seek help:

> *Rosie (CL): my fears were always that if I told somebody about this then I would be committed to a mental institution . . . I was thinking about my career as well . . . and I thought any, if I blot my copy book with this mental illness, I'll never be for anything, I'll never . . . achieve my goal, my dream.*

The findings provided evidence of internalised stigma, whereby those who had felt discredited and stigmatised when they self-injured subsequently judged and stigmatised other people who self-injure. One client spoke about her teenage daughter who has started to cut:

> *Louise (CL): my daughter and her friends have started cutting, I haven't openly admitted to my daughter that I've done it, I don't wanna glorify it for her but because I have been through it I know the signs of it, but I know my daughter's just doing it for attention.*

Louise goes on to explain her opinion: "*you're a freak if you do it, as simple as that*." Louise self-injured throughout her teenage years and most of her twenties and conveyed both an awareness of and identification with society's antipathy towards people who self-injure.

Clients recognised that their behaviour might be met with misunderstanding, labels and inappropriate treatment:

> *Megan (CL): Em I didn't want anyone to think I was going nuts or I was suicidal or anything like that there, I was just for a long time trying to, it was a coping mechanism.*

The clients reported their efforts to hide their self-injury from others, representing a tacit cognisance of the potential consequences if others became aware. One of the counsellors related his perspective that stigma compounds the hidden nature of self-injury, which means that people in distress often remain under the radar of the treatment system.

> *Phil (CO): I think one of the bigger problems with self-injury is it's so hidden, so we're not getting to people who are hiding. I'm not so sure how we can . . . I suppose what we can do is, if the attitudes towards self-injury were to change, then maybe the secrecy could be dropped a little.*

The findings reported evidence of information management strategies, including "passing" and "cover stories" (Goffman, 1963). Martina (CL) "*wore bracelets*" to hide cuts and Louise (CL) discussed maintaining the level of injury so that it would not be detected or could be passed off as minor accidents if anyone did notice. Louise disclosed that on one occasion when her mother noticed cuts and accused her of self-injury, she told a cover story and then reverted to passing: "*So from then on I made sure that I hid it better, I didn't let her see what I was doing.*" Moreover, clients appeared to engage in emotion work (Hochschild, 1979) by presenting a façade in social interactions, for instance pretending to be "*a happy, strong kinda person*" (Martina) or "*appearing normal to the rest of the world*" (Hannah) so that others

were not aware of the emotional pain they were experiencing at the time they were engaging in self-injury.

This category has presented the ways in which social stigma interacts with the existent sense of shame that leads to self-injury. This interaction causes a complex manifestation of self-stigma, whereby the person internalises society's negative judgment and perceives it to be legitimate. The shame and self-stigma reinforce the urge to hide self-injury.

Discussion

This article provides important insights about the impact of stigma on people who self-injure at the community, treatment system and individual levels. Moreover, the article contributes to the theoretical development of stigma in mental illness and thus enhances understanding of self-injury, stigma and help-seeking.

The findings provided evidence to suggest that people who self-injure experience two types of stigma; moral, on the basis of perceived mental illness as well as physical; because of visible wounds and scars on their body (Goffman, 1963). Existing research suggests that groups of people who are already marginalised within society are also more likely to self-injure (Babiker & Arnold, 1997). This proposition was evident in the findings, wherein experiences of psychiatric hospitalisation in youth lead to a sense of social exclusion for one participant. This finding suggests that people who self-injure might experience a double stigma (Grossman, 1991) or layering of stigma (Reidpath & Chan, 2005), initially on the basis of the life conditions that contributed to their self-injury and subsequently on the basis of their self-injury.

Recent research on the public stigma of mental illness revealed that stigmatising responses were significantly stronger towards types of mental illness perceived to infer "dangerousness to self and others" and thus perceptions of potential violence (Pescosolido, 2013). One of the participants in the current study spoke about the negative impact of stereotyping on the basis of mental illness and self-injury. This participant referred specifically to the role of the media in perpetuating the myth of mental illness as indicative of violent tendencies and reflected upon the impact he perceived this to have on his efforts to recover. The current article demonstrates that recipients of stigma are acutely aware of the portrayal of negative stereotypes at a macro level by the media and the impact on public attitudes, which ultimately diminishes the person's own life chances.

The findings contrasted perspectives on the media's representation of self-injury among musical subcultures. Adler & Adler (2007) postulate that there has been a cultural shift whereby self-injury has become a deviant choice among specific subcultures that associate with musical genres such as 'Emo' and 'Goth'. For the clients in the current study, whose life histories included abuse, trauma and victimisation, this conceptualisation of self-injury not only trivialises their emotional pain but adds another level of stigma by applying a label of deviance to the existent label of psychopathology. We suggest that this approach to understanding self-injury by a practitioner in the treatment system might have consequences for the standard of care provided, which communicates assumptions and disregards the painful life history that underlies the behaviour.

The current article offers significant development to mental health research by enhancing understanding of the role of emotions in shaping stigmatising responses (Pescosolido & Martin, 2008) to people who self-injure. The findings reported that fear and a lack of

understanding about self-injury often manifests as a need to rescue among counsellors. Fear was reported to be a dominant, motivating response along with other more hostile reactions such as anger and frustration in situations where counsellors struggled to understand self-injury. The findings suggested fear among counsellors could lead them to prioritise behavioural interventions in an effort to stop self-injury rather than attempt to understand the underlying reasons for self-injury. This type of approach to working with self-injury has been reported to silence life histories of abuse and oppression, and thus locates blame within the person, disregarding the dysfunctional social conditions in which self-injury flourishes (Proctor, 2007; Warner and Spandler, 2012).

The findings suggested that labelling people who self-injure in the treatment system could be conceptualised in psychoanalytic terms as the defence mechanisms splitting and projection (Bion, 1961). By labelling people who self-injure as "cutters", counsellors distance their in-group from the "other", thereby denying their own potential for self-destruction. Bion (1961) asserts that splitting and projection are in-group defences enacted in situations where groups perceive their identity to be threatened by the 'other' out-group. Thus the helper who feels "lost and deskilled" (Simpson, 2006, p. 433) when faced with a person who self-injures, might seek to ameliorate that sense of helplessness by erecting defences that label the 'other', those who self-injure as pathological or deviant and so protect the in-group identity as "preservers of life" (Allen, 2007, p. 173). Theoretical insights from psychoanalysis (Bion, 1961) offer an important contribution to the FINIS (Pescosolido et al., 2008), to enhance understanding of stigma at a meso level in the treatment system.

This article provides a new perspective by exploring the role of emotions in self-labelling, among people who self-injure. The findings reported that social stigma in relation to

psychiatric services and mental health issues can evoke a sense of fear in the person who self-injures, aggravating the person's already diminished self-esteem, reducing the likelihood that they will engage with services. Fear of being labelled mentally ill and the consequences of such a label, impedes their willingness to seek help and comply with treatment. In addition, the findings supported existing research, which denoted a significant link between shame and willingness to seek help (Biddle Donovan, Sharp & Gunnell, 2007; Corrigan, 2004; Kondrat & Teater, 2009; Link & Phelan, 2006; Longden & Proctor, 2012; Markowitz, Angell & Greenberg, 2011; Pescosolido, 2013; Pescosolido et al., 2008; Scambler, 2009; Urquart Law et al., 2009; Vogel, Wade & Hackler, 2007). Existing literature suggested that shame both creates and compounds the hidden nature of self-injury (Tantam & Huband, 2009). This article demonstrates that shame prevents disclosure and help-seeking because of legitimate fears that to do so might generate further shame, stigma and labelling.

Chandler (2012) conceptualised self-injury as embodied emotion work (Hochschild, 1979), whereby people alleviate emotional pain by enacting physical pain on the body. The findings extended Chandler's (2012) research by suggesting that hidden self-injury represents two types of emotion work, embodied and expressive. Some participants reported presenting a particular image, such as acting "happy" or "strong" to detract from their self-injury, thus managing emotions with expressive emotion work, which in symbolic interactionist terms, acts as a form of passing. The findings suggested that while the act of self-injury is a form of embodied emotion work, the experience of being a person who self-injures demands a more complex weave of embodied and expressive emotion work and stigma management. Aligning with modified labelling theory (Link, 1989), people who self-injure use secrecy to cope with the threat of stigma. Consistent with the work of Pachankis (2007) and Markowitz

(1998), evidently concealing a stigma is a considerable psychological burden posing myriad problems for the person.

This article has shown that FINIS offers a holistic theoretical framework to form the basis of understanding stigma towards people who self-injure. This article extends the FINIS by applying new theoretical insights from psychoanalysis and the sociology of emotions that further elucidate understanding of the stigma of self-injury. Consequently, this article demonstrates that stigma enacted in society and the treatment system, permeates the lives of people who self-injure, ultimately impacting negatively on their identity. Stigmatising responses in the treatment system incorporate an overreliance on behavioural interventions that prioritise self-injury cessation over efforts to understand context and motivation. The interaction of social stigma and self-stigma consolidates existent feelings of shame, compounding the hidden nature of self-injury. Thus the experience of stigma renders recovery from self-injury a particularly complex task.

Limitations

A core limitation of the research stemmed from efforts to meet the requirements for ethical approval, which demanded that participants were engaged in counselling at the time of research participation. This requirement seemed to contradict the aim to recruit participants from the hidden population of self-injury. While acknowledging that participant safety is paramount, the process of managing the seemingly diametrical demands of social research into complex and sensitive phenomena within the parameters of research governance has raised a useful point for future scholarly inquiry. Indeed the assumption that people engaged in self-injury who are not availing of counselling would not be in a position to participate in research could be indicative of the nature of structural level stigmatisation, that this study

sought to explore. Nonetheless, all participants in the research were in a position to reflect on experiences of hidden self-injury despite having sought help in subsequent years.

Conclusions

This article has demonstrated that self-injury stigma profoundly impacts upon the person's capacity for help seeking and prospects for recovery. It is imperative to reduce stigma and shame to foster help-seeking behaviours among people who self-injure. Self-injury awareness training for practitioners who work in the field represents one means through which stigma could be challenged to improve clinical practice. It is crucial for service-providers and policy-makers to become aware of the multifarious manifestations of stigma, including those more insidious permutations among often well-intentioned practitioners, which reinforce the devastating impact of self-injury on people's lives. Finally, recommendations for future research on this under-researched topic could explore the effects of the layering of self-injury stigma among marginalised groups as well as accessing people who engage in hidden self-injury on an ongoing basis.

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